STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085004	A. BUILDING _____ B. WING _____	10/01/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDYWINE NURSING & REHABILITATION CENTER	505 GREENBANK ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced annual survey and complaint visit was conducted at this facility from September 22, 2010 through October 1, 2010. The deficiencies contained in this report are based on observations, staff and resident interviews, clinical record reviews, review of facility policies and procedures and other documentation as indicated. The facility census on the first day of the survey was 165 residents. The survey sample totaled 28 residents.	F 000	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of correction is submitted to meet requirements established by state and federal law.	
F 241 SS=B	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations and interviews it was determined that the facility failed to ensure that many residents were treated in a dignified manner. Residents were served milk from cartons during meals without being provided with beverage glasses. Additionally, other beverages were served in disposable, plastic cups. Findings include: During mid-day meal dining observations on 9/22/10, residents in the Elsmere and Greenbank dining rooms were served milk directly from individual cartons and were not provided glasses or straws from which to drink. Additionally, residents were served other beverages from disposable, plastic cups.	F 241	F Tag 241 1. It is the policy of Brandywine Nursing and Rehab to promote care for residents that maintains and enhances each resident's sense of dignity, and to restore, if possible, normal eating skills. Please note that it is common for residents to receive small cartons of milk on their trays for use not as a primary beverage, but rather for use in their coffee, tea, cereal and oatmeal. All milk and juice containers placed on resident's trays are now accompanied by non-disposable glasses. 2. All residents that eat (are not tube fed) have the potential to be affected by the cited deficiency. 3. To enhance currently compliant operations and under the direction of the director of dietary services, as of 10/5/10 all milk and/or juice containers are served with accompanying non-disposable glasses.	10/5/10 10/5/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Fred DiBartolo — TITLE: Administrator — (X6) DATE: 10/21/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 Meal observations throughout the survey period revealed that residents in the Elsmere dining room were served beverages in disposable, plastic cups. During an interview with E13 (Food Service Director) on 9/30/10, he stated that there were not enough non-disposable glasses for all of the residents and that they had just ordered more.	F 241	4. Effective 10/19/10, a quality-assurance program was implemented by the director of dietary services to randomly audit twenty-five percent of all meals trays three times a week to ensure the appropriate number of non-disposable glasses are on each tray. Findings of these audits will be reported at the quarterly quality-assurance committee meeting for further review or corrective action.	10/19/10
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations throughout the survey and the environmental tour with the facility maintenance director on 9/27/10, it was determined that the facility failed to provide maintenance and housekeeping services necessary to maintain an orderly and sanitary interior. Findings include: 1. Unpainted, dirty or scratched walls were observed in resident rooms: F3, F6, F9, F11, F14, G2, G4, G8, and E14. 2. Odors were detected in resident rooms C6, D11, D12 and D14. Additionally, the E-Wing soiled utility room had odors and the exhaust vent was not working. 3. The caulking around the base of the toilets in resident bathrooms C6, C10, D6, D8, D11, D12, F9, F11, E15, F6, G8, and G16 were observed	F 253	F Tag 253 1. It is the policy of Brandywine Nursing and Rehab to provide a clean, safe, homelike environment that promotes healing, comfort and privacy. As of 10/19/10, these items have been cleaned and repaired. 2. All residents have the potential to be affected by this cited deficiency. 3. Weekly Environmental Rounds were initiated and conducted by the director of maintenance on 10/5/10 to identify and correct any housekeeping and/or maintenance concerns. Such rounds and corrective actions that result from findings during these rounds will continue to be conducted by the director of maintenance or his designee. 4. Effective 10/19/2010, a quality-assurance program was implemented by the director of maintenance and housekeeping services to ensure the appropriate actions are being followed to maintain a clean, orderly, sanitary and aesthetically pleasing environment, based on . Findings of these audits will be immediately addressed and ultimately reported at the quarterly quality assurance committee meeting for further review or corrective action per recommendations of the quality assurance committee.	10/19/10 10/5/10 10/19/10

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F 253	Continued From page 2 brown, stained and in disrepair. 4. The bathroom floor edges were observed encrusted with dirt in resident room F11 and other rooms in the F-Wing. 5. Dirt/debris was observed on over the bed tables in rooms B12B and F11A. 6. Toilets were observed cracked or in disrepair in resident rooms F6, G16 and the F-Wing central bath. On 9/27/10, an interview with E19 (Environmental Director) confirmed these findings.	F 253		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a	F 278	F Tag 278 1. R 168 was assigned a new three day voiding diary to accurately assess her urinary continence, and her MDS was subsequently coded correctly. 2. All residents have the potential to be affected by this cited deficiency. 3. On 10/5/10 an in service was completed by the Assistant Director of Nursing with the RNAC to ensure the RNAC had a better understanding of coding for incontinence, to ensure that the RNAC would code even slight urinary leakage between voiding as incontinence that required coding as such. 4. On 10/5/10 a quality assurance program was developed and implemented by the Director of Nursing to randomly review 5 MDS' each week to ensure that the coding for continence matched the CNA and nursing documentation. These weekly	9/30/10 10/5/10 10/5/10

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F 278	Continued From page 3 resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the MDS assessment for one (R168) of 28 residents reviewed did not accurately reflected the resident's status. The facility failed to reflect R168's urinary incontinence in her MDS assessment, dated 5/21/10. Previous MDS assessments revealed that R168 was continent of urine. Findings include: R168 was admitted to the facility on 3/30/10. The admission MDS, dated 4/6/10, stated that R168 was a "0" or fully continent of bladder. The Medicare 14 day, Medicare 30 day and Medicare 60 day MDS assessments, dated 4/9/10, 4/19/10 and 5/21/10 consecutively, continued to reflect that R168 was continent of urine. Review of CNA (certified nurses aide) worksheets revealed that for the 14 day look back period (5/8 to 5/21) used to determine R168's continence status for the 5/21/10 MDS, she was incontinent of urine 10 times and was not fully incontinent of urine as determined on the 5/21/10 MDS assessment. During an interview with E15 (RNAC) on 9/29/10, she confirmed that the Medicare 60 day MDS was incorrect and it should have been coded as a "2" for occasional incontinence.	F 278	reviews will be conducted by the DON or designee, and results will be reported at quarterly quality assurance committee meetings, and should any further coding education be determined to be necessary after the QA meetings, it will be provided by the DON, ADON or Staff Developer.	

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F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure that one (R176) out of 28 sampled residents was provided with care as indicated in the plan of care. Findings include: R176 was admitted to the facility on 6/18/10 with multiple diagnoses including Parkinson's disease, paralysis and dementia. Review of R176's clinical record revealed that she had a total of 12 falls since admission to the facility. R176's quarterly Minimum Data Set (MDS) assessment, dated 9/20/10, indicated that she required extensive assistance with toileting. Review of incident reports, dated 9/20/10 and 9/22/10 revealed that R176 fell on both occasions while trying to go to the bathroom alone. R176's care plan for "Potential for injury related to: decreased mobility and cognition secondary to dementia, Parkinson's (has history of falls prior to admit)..." last updated on 9/22/10, included the	F 309	F Tag 309 1. During the survey R176's bathroom door alarm was discontinued as a fall prevention intervention at the insistence of the resident and the resident's power-of-attorney. 2. All residents have the potential to be affected by this cited deficiency. 3. Beginning 10/2/10, and having been completed by 10/5/10, all CNA care plans were reviewed by the DON and ADON to ensure that the CNA care plans were complete and accurate; clear and concise. 4. On 10/5/10 a quality assurance program was developed and implemented by the Director of Nursing to randomly review 5 CNA care plans each week to check for accuracy and comprehensiveness. These weekly reviews will be conducted by the DON, ADON or designee, any inaccuracies will be immediately corrected, and results will be reported at quarterly quality assurance committee meetings. The QA committee will then recommend if any system changes are needed to ensure ongoing accuracy of the CNA care plans.	9/29/10 10/5/10 10/5/10

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F 309	Continued From page 5 approach, "BR (bathroom) door alarm added." On 9/28/10 at 2:05 PM, R176 was observed sitting alone in her room. The bathroom alarm was observed hanging from the door jam and was disconnected. On 9/29/10 at 2:30 PM, R176 was observed sitting alone in her room and again, the bathroom alarm was disconnected. On 9/29/10, during an interview with E14 (Certified Nurse Aide-CNA), who was assigned to R176 that day, stated that she did not know anything about the bathroom alarm. At 2:40 PM on 9/29/10, E12 (nurse) confirmed that the bathroom alarm should have been connected. When asked how the information from residents' care plans was communicated with the CNA's, she stated that it should have been on the CNA care plan. R176's CNA care plan lacked information regarding the bathroom alarm. E12 confirmed that the bathroom alarm was missing from the CNA care plan and stated that it should have been added when the intervention was added to the care plan. The facility failed to follow R176's care plan regarding the implementation of a bathroom alarm to alert staff when the resident attempted to toilet herself. This intervention was put into place to help prevent injuries for this resident with a history of numerous falls.	F 309	F Tag 309 1. During the survey R176's bathroom door alarm was discontinued as a fall prevention intervention at the insistence of the resident and the resident's power-of-attorney. 2. All residents have the potential to be affected by this cited deficiency. 3. Beginning 10/2/10, and having been completed by 10/5/10, all CNA care plans were reviewed by the DON and ADON to ensure that the CNA care plans were complete and accurate; clear and concise. 4. On 10/5/10 a quality assurance program was developed and implemented by the Director of Nursing to randomly review 5 CNA care plans each week to check for accuracy and comprehensiveness. These weekly reviews will be conducted by the DON, ADON or designee, any inaccuracies will be immediately corrected, and results will be reported at quarterly quality assurance committee meetings. The QA committee will then recommend if any system changes are needed to ensure ongoing accuracy of the CNA care plans.	9/28/10 10/5/10 10/5/10
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441	F Tag 441 1. As documented in the Statement of Deficiencies, Brandywine Nursing and	

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F 441	Continued From page 6 safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on review of facility documents and staff interviews, it was determined that the facility failed	F 441	Rehab had put in place a program to act upon the findings of infection data in August, 2010. Therefore the deficient practice had been corrected by the time of the survey; the citation is for the time period preceding August, 2010. 2. All residents had the potential to be affected by this cited deficiency. 3. Beginning August 1, 2010, a new system for analyzing infection data, and ensuring appropriate actions were taken based on this analysis, was put in place. 4. Beginning 10/13/10, review of the infection data, the analysis of the data, and actions taken as a result of the analysis is now conducted at weekly Interdisciplinary Team Meetings. A thorough review of all infection data and its subsequent analysis will be reviewed at quarterly quality assurance meetings, with the Medical Director and the Director of Nursing ultimately determining if any changes need to be made to the current system for analyzing infection monitoring and control.	8/1/10 8/1/10 10/13/10

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F 441	Continued From page 7 to maintain an infection control program under which it investigated and analyzed any increase in the rate of infection to prevent the development and transmission of disease and infections. Findings include: The facility's Infection Control Policy was reviewed. Review of the Monthly Infection Control Logs or records for March 2010 through August 2010 with E20 (Infection Control Nurse) revealed that the facility monitored the occurrence of infections, however, it failed to analyze changes in the infection rates, and failed to establish controls to prevent the spread of infections in the facility. The facility failed to act upon the findings of infection data until the month of August 2010. On 10/1/10, E20 confirmed these findings.	F 441		
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined that the facility failed to ensure that the resident call system was functional for 10 residents in their rooms or bathrooms (R37, R44, R45, R61, R95, R102, R104, R120, R146, and R188) out of 40 rooms reviewed. Findings include:	F 463	F 463 1. Prior to the completion of the survey on 10/1/10, all call bells, call lights, and call response systems were repaired. 2. All residents had the potential to be affected by this cited deficiency. 3. Prior to the survey, Brandywine Nursing and Rehab had purchased a wireless call system that communicates to a central monitor at each nurse's station and a pager carried by the nurses. During the survey a representative of the company that manufactures this new wireless system, which is intended to be used as a back-up system should a residents call system fail, programmed the system and	10/1/10 10/1/10

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F 463	Continued From page 8 The monthly tracking of the "Nurse Call" (call light system) per the maintenance log revealed that 2 rooms are randomly chosen on each unit to be checked each month. 1. On 9/23/10, an observation revealed that the call system in R45's room was not functional. On 9/23/10, findings were confirmed by both E5 (CNA) and E4 (RN). R45 was able to use the call light. E4 stated that she would notify Maintenance to fix it. An observation on 9/23/10 in the late afternoon revealed that Maintenance had repaired the call system for R45. 2. On 9/23/10, an observation revealed that the call system in R120's room was not functional. An interview with E6 (LPN) on 10/1/10 revealed that R120 was able to use the call light. On 9/23/10, findings were confirmed by E4 (RN). E4 stated that the call lights for R120 and R45 shared a common cord and that she would notify Maintenance to fix it. Observation on 9/23/10 in the late afternoon revealed that Maintenance had repaired the call system for R120. 3. On 9/23/10, an observation of the bathroom for R37 was made and revealed that the bathroom call system was not functional. It rang but did not light up in the hallway. R37 was able to use the call light. On 9/23/10, findings were confirmed by E7 (CNA) and E8 (CNA). Maintenance was notified and repaired the bathroom call system on 9/23/10. 4. On 9/23/10, an observation of the bathroom for R44 was made and revealed that the bathroom call system was not functional. It rang but did not light up in the hallway. On 9/23/10, findings were confirmed by E7 (CNA) and E8 (CNA).	F 463	had made it fully operational prior to the completion of the survey on 10/1/10. Therefore, prior to the end of the survey there was a system in place that should a call bell be found to be not working, a wireless call system can be utilized immediately while awaiting repair of the main call system. In addition, all call systems are checked during Weekly Environmental Rounds, which were initiated and conducted by the director of maintenance on 10/5/10. Such rounds and corrective actions that result from findings during these rounds, including immediate repair of call systems, will continue to be conducted by the director of maintenance or his designee. The wireless, back-up call system will continue to be inspected weekly to make sure it remains constantly in working order and available as an instant solution to a non-working call bell. 4. Effective 10/19/10 a quality-assurance program was implemented by the director of maintenance and housekeeping services to perform in-depth maintenance and housekeeping rounds, with special attention to all call systems, with a team consisting of the director of maintenance or his designee, the Infection Control Nurse or his designee, and the Administrator or his designee, checking the facility to ensure the appropriate actions are being followed to maintain a clean, orderly, sanitary and aesthetically pleasing environment, with all call systems in working order. Results of these rounds will be reported by the director of maintenance at quarterly quality assurance meetings, and the quality assurance committee will make recommendations	10/19/10

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F 463	Continued From page 9 Maintenance was notified and repaired the bathroom call system on 9/23/10. 5. On 9/23/10, an observation of the bathroom for R61 was made and revealed that the bathroom call system was not functional. It rang but did not light up in the hallway. R61 was able to use the call light. On 9/23/10, findings were confirmed by E7 (CNA) and E8 (CNA). Maintenance was notified and repaired the bathroom call system on 9/23/10. 6. Observation of R188's bedside call light on 9/22/10 at 11:32 AM revealed that the call light was not functioning (no audio or visual). The non-functioning call light was verified by E9 (nurse), who then notified the maintenance department. 7. Observation of R102's bedside call light on 9/23/10 at 12:00 PM revealed that an audible alarm was heard in the hallway, however the light over the doorway was not functioning. E10 (restorative aide) was observed walking down the hallway trying to determine which room's call light was sounding. 8. Observation of R146's bathroom call light on 9/23/10 at 1:40 PM revealed that the call light was not functioning (no audio or visual). The non-functioning bathroom call light was verified by E11 (CNA). 9. Observations of R95's room on 9/22/10 revealed a non-functioning call bell. Findings were confirmed by staff.	F 463	based on such reports.	

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F 463	Continued From page 10 10. Observations of R104's bathroom on 9/23/10 revealed a non-functioning call bell. Findings were confirmed by staff.	F 463	F469 1. Brandywines contracted pest control company, Ehrlich, made several additional visits to the facility during which different treatments were conducted to control flying and other pests. This was in addition to the regular service visits. Every part of the facility had been treated by 10/5/10.	10/5/10
F 469 SS=E	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents.	F 469	2. All residents hade the potential to be affected by this cited deficiency.	
	This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, it was determined that the facility failed to ensure an effective pest control program for flies abatement. Findings include:		3. Weekly Environmental Rounds were initiated and conducted by the director of maintenance on 10/5/10 to identify and correct any housekeeping and/or maintenance concerns, including inspecting for signs of flying insects, as well as all pests. Such rounds and corrective actions that result from findings during these rounds will continue to be conducted by the director of maintenance or his designee.	10/5/10
	A review of the most recent facility's "Pest Control Service Agreement" revealed that the pest service to be rendered included flies abatement. Pest control inspection records from 6/10 to 9/10 indicated the facility had inspections done weekly and at times more frequent inspections as requested by the facility. 1. During the tour with E19 (Maintenance Director) on 9/27/10, the following observations were made: a. At 10:45 AM, live flies were observed in resident room F15. Interview with E19 revealed the flies come through the doors. b. At 10:47 AM, live flies were observed in resident room F3. Carts full of trash and soiled linen were observed outside in the hallway of this room.		4. Effective 10/19/2010, a quality-assurance program was implemented by the director of maintenance and housekeeping services to ensure the appropriate actions are being followed to maintain a clean, orderly, sanitary and aesthetically pleasing environment, based on . Findings of these audits will be immediately addressed and ultimately reported at the quarterly quality assurance committee meeting for further review or corrective action per recommendations of the quality assurance committee.	10/19/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085004	A. BUILDING _____ B. WING _____	10/01/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDYWINE NURSING & REHABILITATION CENTER	505 GREENBANK ROAD WILMINGTON, DE 19808

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F 469	Continued From page 11	F 469		

c. At 11:00 AM, numerous live gnats were observed flying around the area inside the F/G hall soiled utility room.

d. At 11:05 AM, flies were observed in resident room C6. An odor was detected in the room.

e. On 9/28/10 at 10:10 AM, two flies were observed near R150 in room B15C during the medication pass observation.

f. On 9/23/10 at 11:30 AM, three to four flies were observed laying on the shoes of R168 in room D6A.

g. On 9/23/10 at 3:47 PM, R136 in room F4A was observed with a fly swatter on his sofa and when the surveyor asked him about it, R136 stated it was to kill the flies that come in the building.

An interview with E19 (Maintenance Director) on 10/1/10 revealed that the flies were coming in through the library door, which is kept open for long periods of time.

2. On 9/23/10 at 11:54 AM, an observation of 3 flies was made. The flies were flying around in room B12B where R61 was laying in bed. R61's bedside stand had debris that was sticky on it. On 9/23/10 at 11:58 AM, E8 (CNA) confirmed that the bedside stand was sticky/dirty, potentially drawing the flies to the room.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 085004	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE 10/1/2010
NAME OF PROVIDER OR SUPPLIER BRANDYWINE NURSING & REHABILITATION CEI	STREET ADDRESS, CITY, STATE, ZIP CODE 505 GREENBANK ROAD WILMINGTON, DE		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 156	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate The facility must furnish a written description of legal rights which includes A description of the manner of protecting personal funds, under paragraph(c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.

Any deficiency statement ending with an asterisk(*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

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NAME OF PROVIDER OR SUPPLIER BRANDYWINE NURSING & REHABILITATION CE	STREET ADDRESS, CITY, STATE, ZIP CODE 505 GREENBANK ROAD WILMINGTON, DE		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 156	Continued From Page 1 The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits This REQUIREMENT is not met as evidenced by: Based on review of facility records and interviews, it was determined that the facility failed to provide notice of termination of benefits prior to the day services were discontinued for one(R160) out of three residents reviewed. Findings include: Review of the facility's liability notices on 9/24/10 revealed that a notice of Medicare Provider Non-coverage letter (Medicare cut letter) was not provided for R160, therefore, the resident was not notified when and why coverage was discontinued. There was no evidence that the resident (or family) was provided with a notice before the date of noncoverage of skilled service. Review of facility procedures entitled, "Demand Bills Policy and Procedures" stated "if the facility believed Medicare will not pay for skilled nursing or specialized rehabilitative services... the facility will notify the resident or his/her legal representative in writing and explain why these specific services may not be covered....." The procedure did not address when they need to notify the resident or family member On 9/29/10, interviews with E15 (Registered Nurse Assessment Coordinator), who is responsible for the Medicare cut letters, confirmed these findings. On 10/4/10, the cut letter for R160 was faxed to the State Agency. The cut letter was signed by the family member a day after the noncoverage of medicare service and not prior to the end of service
F 247	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and resident and staff interviews, it was determined that the facility failed to ensure that one (R182) of 28 sampled residents, received notice before the resident's roommate in the facility was changed. Findings include: The facility's policies and procedures entitled "Social Service Room Change Policy and Procedure" were reviewed. Step 2 of the procedure stated "the IDT (Interdisciplinary Team) will discuss roommate

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NAME OF PROVIDER OR SUPPLIER BRANDYWINE NURSING & REHABILITATION CEI	STREET ADDRESS, CITY, STATE, ZIP CODE 505 GREENBANK ROAD WILMINGTON, DE		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 247	Continued From Page 2

compatibility and confer with and notify the resident involved or their RP (Responsible Party) if resident unable to understand the change". Step 3 stated "While adequate notice should be given to the residents and roommates in most situations, occasions may arise where resident safety and/or the health.....effort shall be made to notify the resident, roommates, and/or families in a timely manner".

R182 was admitted to the facility on 1/29/10. R182's quarterly Minimum Data Set (MDS) assessment, dated 8/2/10, indicated R182's cognitive skills for daily decision making were modified independence.

Interview with R182 on 9/22/10 at 10:55 AM revealed that she had not been informed of roommate changes. R182 confirmed she had new roommates in the past nine months.

Review of R182's clinical record, including social service notes, lacked evidence that this resident and/or family were given notice before a roommate change was done.

Interview with E16 (Unit Clerk) and E17 (Nurse) on 9/29/10 at 2:49 PM revealed that R182 had several roommate changes. E16 stated that R182 had three roommate changes in the past nine months.

Interview with E18 (Social Service) on 9/30/10 at 8:01 AM revealed that R182 had roommate changes, but that she did not document it. E18 stated that R182 had been told but that the resident did not remember.

Interview with R182 on 9/29/10 at 10:40 AM revealed that she has had various roommates, but has not been informed prior to their arrival.

Interview with R182's POA (Power of Attorney) on 9/29/10 at 2:18 PM revealed that R182 had three to four roommate changes since R182's admission to the facility, but she was not informed prior to the moves.

DELAWARE HEALTH
AND SOCIAL SERVICES
Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Brandywine Nursing Rehabilitation Center DATE SURVEY COMPLETED: October 1, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3201	**Skilled and Intermediate Care Nursing Facilities** **The State Report incorporates by reference and also cites the findings specified in the Federal Report.** An unannounced annual survey and complaint visit was conducted at this facility from September 22, 2010 through October 1, 2010. The deficiencies contained in this report are based on observations, staff and resident interviews, clinical record reviews, review of facility policies and procedures and other documentation as indicated. The facility census on the first day of the survey was 165 residents. The survey sample totaled 28 residents.	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire**	

Provider's Signature Fred A. Bartoli Title Administrator Date 10/21/10

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STATE SURVEY REPORT

NAME OF FACILITY: Brandywine Nursing Rehabilitation Center DATE SURVEY COMPLETED: October 1, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	Prevention Commission are hereby adopted and incorporated by reference. **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L, survey date completed 10/1/10, F156, F241, F247, F253, F278, F309, F441, F463, and F469.	Please refer to CMS 2567-L, survey date completed 10/1/10, F156, F241, F247, F253, F278, F309, F441, F463, and F469.